KENTUCKY BOARD OF
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

P. O. BOX 1360
FRANKFORT, KENTUCKY 40602
http://www.state.ky.us/agencies/finance/occupations

APPLICATION FOR REINSTATEMENT

[ ] Speech-Language Pathology (Complete front of application only)
[ ] Audiology (Complete front of application only)
[ ] Speech-Language Pathology Assistant (Complete front and back of application)

Please type or print:

1. Name:		License Number:
2. Address:		Social Security Number:
3. Work Number:	4. Home Number:	
5. Name license was issued under:		
6. Do you currently hold a license in any other state(s)? [ ] Yes [ ] No If yes, please list the state(s): _____ **Letters of good standing from each state (active, inactive, or expired) must be forwarded to this office. Your license cannot be reinstated until all documents have been received.**		
7. Do you have any complaints currently pending against a license held by you in any other state(s) ? [ ] Yes [ ] No If yes, attach explanation(s).		
8. Have you been convicted of any felony since the time of your initial licensing in Kentucky? [ ] Yes [ ] No If yes, attach explanation(s).		
9. Date of expiration of your Kentucky License?		
10. List all places of employment and dates since your license expired in Kentucky:		
11. Attach reinstatement fee of **$125.00**. Please make check or money order payable to the **Kentucky State Treasurer. DO NOT SEND CASH.**		
12. Attach evidence of completion of fifteen hours of continuing education in the past twelve months. If you do not have these hours, please attach a letter stating that you do not have the hours.		

SIGNATURE OF APPLICANT: _____ **DATE:** _____

For Board Use Only

Fee Receipt Date: _____
Amount: $_____

Approved: _____ Denied: _____
Board Members Initials: _____
_____

TO BE COMPLETED BY SUPERVISOR: This section must be completed. Incomplete forms will be returned. Please check the appropriate box or boxes:

School System: _____ Business Telephone Number: ( ) _____

School Name(s) _____

Address: _____
Street City State Zip Code

I am the original supervisor for this licensee.

I am not the original supervisor for this licensee. I began supervising this individual on _____.

I recommend that this individual's speech-language pathology assistant license be reinstated and hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:027 for this licensee to function as a speech-language pathology assistant during the period of this license. I further agree to accept responsibility for the practice and activities of this licensee in his/her capacity as a speech-language pathology assistant. I acknowledge that the failure to utilize this person appropriately as a speech-language assistant and to supervise in accordance with the above cited provisions of Chapter 334A of the Kentucky Revised Statues and the administrative regulations promulgated thereunder, shall be considered as aiding and abetting an unlicensed person to practice speech-language pathology as described in KRS Chapter 334A.

I do not recommend that this individual's speech-language pathology assistant license be reinstated. Please explain on a separate sheet of paper and attach to this reinstatement application.

Supervisor's Comments: _____

_____

_____

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I hereby certify that all information provided on this form is true and correct to the best of my knowledge.

_____ _____
Supervisors Signature **Date**

_____ _____
Street Address **Phone Number**

_____ _____
City, State, Zip Code **License or Certificate Number**
If you are not the original supervisor and do not hold a Kentucky Speech-Language Pathology License, please attach a copy of your Kentucky Teaching Certificate.